Michigan Department of Health and Human Services (MDHHS)

Michigan Drug Assistance Program (MIDAP)

Patient Consent Form

This document is to help you understand the medications prescribed to you to treat your hepatitis C. Your doctor should talk to you about some very important things before you begin this medication. Please read the following statements below and initial after each statement.

_____ I understand that I must take these medications as my doctor has prescribed.

_____ If I do not strictly follow the instructions for my medication, it may not work.

_____ I understand that bloodwork is required even after I finish my medication. I agree to follow-up with my doctor after I finish my medication.

_____ I will not drink alcohol. Alcohol can hurt my liver. If I do drink alcohol, MIDAP will not pay for my Hepatitis C medication.

_____ I will not use illegal substances or drugs. If I use illegal substances, MIDAP will not pay for my Hepatitis C medication.

_____ If I am on more than one medication for Hepatitis C, I agree to take them all as directed. If I stop one of my medications, then the other will not work.

_____ I understand that lost and/or stolen replacement requests for medications may not be authorized.

_____ I understand how I am supposed to take this medication and the possible side effects.

_____ If I have any questions about my medication, I will contact my doctor's office for more information.

I have read, and I understand all the above information. I agree to all terms. If I fail on at least one item listed above, the Michigan Drug Assistance Program will not pay for my Hepatitis C medication.

Name of Patient (Please Print): _____

Signature of Patient: _____ Date: _____

Note: Forms not signed, initialed or dated will not be accepted